STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E528	A. BUILDING _____ B. WING _____	09/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTH CENTER	440 SE WOODLAND AVE TOPEKA, KS 66607

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #77726, #77629, and #77934.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This Requirement is not met as evidenced by: The facility identified a census of 64 residents with a sample size of 22. Based on observation, interview, and record review, the facility failed to	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 164	Continued From page 1	F 164		

provide privacy to 1 of 1 resident's sampled (#75).

Findings included:

- The Quarterly Minimum Data Set 3.0 (MDS) for resident #75 dated 8/714 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the interview. The MDS revealed the resident was independent for bed mobility, transfers, walking in the room, and locomotion on and off the unit. Staff supervised the resident for dressing, eating, toilet use, and personal hygiene.

The Care Area Assessment (CAA) dated 12/2/13 for Psychosocial Well-Being revealed the resident presented with some signs of mood disturbance. He/she could be redirected as needed. The residents symptoms were not unusual for his/her baseline and were consistent with prior assessments.

The care plan dated 8/8/14 revealed the resident did not always remember his/her personal needs. Staff were to help arrange bathing, keeping fingernails short, and cueing him/her to change his/her clothes. He/she typically liked to sleep in during the day time and stayed up at night.

Observation on 9/9/14 at 12:50 P.M. revealed licensed care staff I and administrative nursing staff F entered resident #75's room after pressing a doorbell beside the resident's room. The resident was sleeping in his/her bed. Staff began to strip the resident's bed linens while the resident slept and used Micro Kill wipes as staff removed the sheets. The resident helped turn his/her self

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F 164	Continued From page 2 after being turned by staff. Staff removed the resident's blanket, the resident was nude while laying on his/her bed. Staff opened the resident's bedroom door and left it open while taking his/her linens to laundry cart beside the resident's door. The door was left open for several seconds. Staff covered the resident with a blanket after the bedroom door was closed when staff had removed the linens. Staff I stated the resident usually got aggressive when someone tried to wake him/her. Interview on 9/9/14 at 1:25 P.M. with licensed nursing staff I revealed when staff F opened the bedroom door while the resident was laying in his/her bed fully nude, he/she tried to step in front of the door to cover him/her. He/she stated normally the door should be closed if a resident was nude in his/her room. Interview on 9/9/14 at 2:07 P. M. with administrative nursing staff F stated staff should always intervene and shut the resident's door for privacy when a resident was inappropriately dressed. He/she stated he/she opened the resident's bedroom door to put the dirty laundry out and he/she should have closed the door. The undated facility policy titled Resident's Rights and Quality of Life stated all residents had the right to a dignified existence. The facility failed to provide privacy during cares for this resident.	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of	F 221		

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F 221	Continued From page 3 discipline or convenience, and not required to treat the resident's medical symptoms. This Requirement is not met as evidenced by: The facility reported a census of 64 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to assess a lap belt used for 1 (#39) of 1 resident sampled for restraints. Findings included: - The quarterly Minimum Data Set (MDS) 3.0 dated 8/14/14 for resident #39 revealed a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). The resident required extensive assistance of two plus (2+) for bed mobility, transfer, and toilet use, extensive assistance of one person for walking in her/his room, dressing, personal hygiene, and bathing; supervision of one person for locomotion on/off the unit, and supervision with setup for eating. The resident was not steady and was only able to stabilize with staff assistance with moving from a seated to standing position, walking, turning around, moving on/off the toilet, and surface to surface transfer. The resident had functional limitations in range of motion (ROM) to both sides of her/his lower extremities and used a wheelchair (w/c) for mobility and did not use a restraint. The fall Care Area Assessment dated 11/29/13 revealed the resident used a w/c for mobility and required assistance with bed mobility, transfers, showers and walking when using arm crutches. The resident stated she/he had not had a fall within the past 30 days prior to admission, but had within the past 6 months. She/he reported	F 221		

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F 221	Continued From page 4 one non-injury occurrence since admission. The updated care plan (CP) dated 8/11/14 and updated on 9/5/14 revealed the resident was at risk for falls and had a diagnosis of cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth). The care plan lacked documentation of a velcro lap belt. Record review on 9/8/14 at 4:00 P.M. lacked documentation/assessment for the use of the lap belt used while the resident used her/his w/c. Observation on 9/3/14 at 1:00 P.M. revealed the resident self-propelled in a w/c with a Velcro lap belt in place. Observation on 9/8/14 at 7:15 A.M. resident self-propelled by the nursing station in a w/c with a Velcro lap belt in place. Interview on 9/9/14 at 9:43 A.M. with direct care staff D stated the resident had a tendency to lean over in her/his w/c and the Velcro strap prevented the resident from falling forward and out the the w/c. Interview on 9/11/14 at 8:45 A.M. with direct care staff R stated the resident used the lap belt for safety. Interview on 9/9/14 at 10:17 A.M. with licensed nursing staff H stated she/he was not sure why the resident used the Velcro strap when the resident used the w/c. The resident's w/c had the strap in place when she/he was admitted to the facility.	F 221		

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F 221	Continued From page 5 Interview on 9/11/14 at 1:19 P.M. with licensed nursing staff I stated the resident admitted with with the Velcro belt and it was used to keep the resident from bending over too much in her/his w/c. Interview on 9/9/14 at 1:08 P.M. with administrative nursing staff D stated the w/c came with the lap belt and was not assessed or care planned as the resident was able to remove the strap on her/his own. The facility failed to assess the Velcro lap belt used for this resident.	F 221		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272		

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F 272	Continued From page 6 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This Requirement is not met as evidenced by: The facility identified a census of 64 residents. The sample included 22 residents. Based on observation, record review, and interview the facility failed to complete triggered Care Area Assessments for 1 (#64) of the 22 residents reviewed in the sample. Findings included: - The quarterly Minimum Data Set 3.0 (MDS) dated 5/29/14 for resident #64 revealed a Brief Interview for Mental status (BIMS) score of 13, indicating no cognitive impairment. The resident displayed delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue) and fluctuating signs of delirium (sudden severe confusion, disorientation and restlessness) including inattention and disorganized thinking. Documentation showed the care area assessment (CAA) for Delirium and Mood state triggered from the assessment. The record review revealed the faciltiy failed to complete the CAA for Delirium and the CAA for	F 272		

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F 272	Continued From page 7 Mood State. Observation on 9/3/14 at 3:14 P.M. revealed the resident sat at a table in the dining room eating popcorn and singing with staff and another resident. Interview on 9/11/14 at 1:23 P.M. with administrative nursing staff E revealed he/she expected staff to complete all triggered CAAs. Staff E acknowledged this resident's triggered CAAs for Delirium and Mood state were not completed. Interview on 9/11/14 at 1:41 P.M. with administrative nursing staff D revealed he/she expected staff to complete all triggered CAAs. The undated policy provided by the facility regarding the MDS revealed the facility conducted the MDS according to Federal regulations and Medicare guidelines. The facility failed to complete all triggered CAAs for this resident.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		

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F 279	Continued From page 8 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility reported a census of 64 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to provide a comprehensive care plan for the use of a lap belt used for 1 (#39) resident in the sample. Findings included: - The quarterly Minimum Data Set (MDS) 3.0 dated 8/14/14 for resident #39 revealed a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). The resident requires extensive assistance of two plus (2+) for bed mobility, transfer, and toilet use, extensive assistance of one person for walking in her/his room, dressing, personal hygiene, and bathing; supervision of one person for locomotion on/off the unit, and supervision with setup for eating. The resident was not steady and was only able to stabilize with staff assistance with moving from a seated to standing position, walking, turning around, moving on/off the toilet, and surface to surface transfer. The resident had functional limitations in range of motion (ROM) to both sides of her/his lower extremities and used a wheelchair (w/c) for mobility and did not use a restraint.	F 279		

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F 279	Continued From page 9 The fall Care Area Assessment dated 11/29/13 revealed the resident used a w/c for mobility and required assistance with bed mobility, transfers, showers and walking when using arm crutches. The updated care plan (CP) dated 8/11/14 and updated on 9/5/14 included the resident was at risk for falls and had a diagnosis of cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth). The care plans dated 8/11/14 and 9/5/14 lacked documentation the resident used a w/c with a Velcro lap belt. Record review on 9/8/14 at 4:00 P.M. lacked documentation/assessment for the use of the lap belt used while the resident used her/his w/c. Observation on 9/3/14 at 1:00 P.M. revealed the resident self-propelled in a w/c with a Velcro lap belt in place. Observation on 9/8/14 at 7:15 A.M. resident self-propelled by the nursing station in a w/c with a Velcro lap belt in place. Interview on 9/9/14 at 9:43 A.M. with direct care staff D stated the resident had a tendency to lean over in her/his w/c and the Velcro strap prevented the resident from falling forward and out the the w/c. Interview on 9/11/14 at 8:45 A.M. with direct care staff R stated the resident used the lap belt for safety. Interview on 9/9/14 at 10:17 A.M. with licensed	F 279		

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F 279	Continued From page 10 nursing staff H stated she/he was not sure why the resident used the Velcro strap when the resident used the w/c. The resident's w/c had the strap in place when she/he admitted to the facility. The MDS coordinator provided the comprehensive care plans. Interview on 9/9/14 at 1:08 P.M. with administrative nursing staff D stated the resident admitted with the lap belt on the w/c and was not assessed or care planned as the resident was able to remove the strap on her/his own. Interview on 9/11/14 at 1:19 P.M. with licensed nursing staff I stated the resident was admitted with the Velcro belt on the w/c and used it to keep the resident from bending over too much in her/his w/c. Interview on 9/11/14 at 3:02 P.M. with administrative nursing staff E stated the lap belt came with the specially made w/c the resident used, and she/he was able to strap and unstrap the belt. The lap belt was not assessed. The undated policy and procedure titled Comprehensive Care Plan revealed each resident's care plan would be individualized and would reflect the physical and psychosocial issues/concerns and interventions for the resident. The preferences and goals of the resident would be given highest priority in the development of the care plan. The facility failed to provide a comprehensive care plan for the use of a Velcro lap belt in the w/c of this resident who required assistance with transfers.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 11 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 64 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to provide supervision for 1 (#60) resident to prevent the resident from leaving the facility unsupervised. Findings included: - The signed Physician's Order Sheet (POS) dated 9/3/14 for resident #60 revealed diagnoses of schizoaffective disorder (a condition in which a person experienced a combination of schizophrenia symptoms - such as hallucinations or delusions - and mood disorder symptoms, such as mania or depression) and dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors. The annual Minimum Data Set (MDS) 3.0 dated 7/17/14 revealed a Brief Interview for Mental Status (BIMS) score of 10 (moderately impaired cognition), demonstrated hallucinations and delusions, and did not demonstrate wandering behaviors. The resident was independent with no set up with bed mobility, transfers, walking in her/his room/corridor, and locomotion on/off the unit. The resident did not have functional range of motion (ROM) problems with her/his upper/lower	F 323		

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extremities and did not use mobility devices. The resident received antipsychotic (medications for psychosis) and antianxiety (medications for anxiety) daily.

The Behavioral Care Area Assessment dated 7/21/14 revealed the resident exhibited delusional based thinking, believed things were one way, based on delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The resident had a history of increased anxiety and paced the halls, and tried to leave the facility. Staff was able to redirect the resident and had a history of needing one to one (1:1) time with staff for re-direction.

The updated care plan dated 8/29/14 for the resident tried to leave the building to return to her/his old home and did not realize the safety risk if she/he went alone, staff would help keep the resident busy with a variety of activities to decrease the chance of wandering. Staff would assist in setting up visiting times with her/his spouse at the facility or at the spouse's home and she/he was educated by staff and social worker to not leave the spouse's home alone and to wait for transportation. The facility made sure staff members were aware of her/his safety risks and ensured the resident's elopement bracelet was on and functioned properly every shift. Staff obtained the resident's picture and kept record of her/his information in case the resident left the building unattended and to help with locating the resident. If the resident attempted to leave the facility, staff walked outside with the resident to re-direct exit seeking behaviors. Staff re-educated the resident on the policy for signing in and out of the facility when leaving and on other options that were better than walking to her/his destination. Staff checked on the resident every 15 minutes,

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ensured her/his safety needs and location.The social worker (SW) spoke with the resident's spouse to arrange a time the facility could assist the resident with visitation as the spouse had limited funds and lacked transportation. The SW spoke with the resident and spouse to set up a calling schedule.

The Complaint/Incident Investigation Report dated 9/2/14 revealed the resident left the facility the evening of 8/28/14 and did not sign out on the evening shift and a staff member on her/his way home saw the resident on 6th and California street. The resident stated she/he was going to see her/his spouse. She/he got into the staff's car and returned to the facility. The resident stated she/he waited for a wheelchair (w/c) bound resident to come inside the facility, and while the door was open, she/he went out the door. The resident was last seen at 9:45 P.M. by the nurse and at 10:10 P.M. the certified nursing assistant (CNA) returned with the resident. Staff placed a wanderguard on the resident and placed on every 15 minute checks to ensure resident safety.

The Elopement Risk Assessment for Mental Health dated 1/7/14 revealed the resident tried to leave the facility at least one time per month to see her/his spouse, demonstrated wandering behaviors, wore a wanderguard to alert staff for resident safety, and had supervision when leaving the facility.

The Elopement Risk Assessment for Mental Health dated 4/17/14 revealed the resident had a history of leaving the facility unattended and against her/his individual treatment plan. She/he was on 15 minute checks and wore a wanderguard. The resident was not to leave the facility unattended.

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F 323	Continued From page 14 The Elopement Risk Assessment for Mental Health dated 7/16/14 revealed the resident displayed wandering behaviors such as attempting to open doors, or moving without purpose or destination. The resident had a history of trying to leave the facility to go home, wore a wanderguard and was on 30 minute checks. The resident was re-directed with offers to go for a walk outside with staff or for staff to provide another activity. Record review on 9/11/14 at 11:25 A.M. the nursing notes lacked documentation of the elopement per policy and procedure and lacked documentation of every 30 minutes checks prior to 8/2914. Observation 9/3/14 at 1:08 P.M. resident attempted to exit the front door by following a staff member who escorted another resident outside. The alarm sounded as the resident neared the door and the staff members redirected the resident. At 1:15 P.M. the resident walked to the front door, attempted to push the door open, the alarm sounded, and the door locked. At 1:28 P.M. activity staff DD ambulated with the resident outside the facility while the resident smoked. Observation on 9/8/14 at 8:50 A.M. the resident ambulated up C hallway, around the nurse's station, and exited the facility by the front door as another resident came in and the wandergard alarmed but did not lock as the front door was in the open position. An unidentified resident yelled to the nursing staff that the resident went outside at the same time staff responded to the alarm. Observation on 9/11/14 at 10:00 A.M.	F 323		

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administrative nursing staff F checked the resident's wanderguard for placement and function.

Observation on 9/11/14 at 10:08 A.M. maintenance staff X checked the front exit door's wanderguard with a new wanderguard and the door locked but did not sound with 2 attempts. She/he checked the door again with an unidentified resident who wore a wanderguard and the front exit door locked but did not sound.

Interview on 9/11/14 at 10:12 A.M. the resident stated she/he did not remember leaving the facility on 8/28/14. She also stated she/he would sneak out of the facility by waiting until someone went out the door.

Interview on 9/11/14 at 1:54 P.M. direct care staff R stated she/he was unsure how the resident got out of the facility. The resident wore a wanderguard even though the resident did not have to have anyone go with her/him when she/he went outside. The resident did not sign out when she/he left the facility and the resident was currently on every 15 minute checks.

Interview on 9/11/14 at 10:00 A.M. administrative nursing staff D stated the front door was unlocked at 6:00 A.M. and locked at 9:00 P.M. It was believed the resident left the facility as resident #39, a wheelchair bound resident, entered the facility through the front door. Resident #39 stated resident #63 disarmed the alarm when it sounded. She/he also stated it was the facility's policy to sign out when a resident left the facility and the resident wore a wanderguard as she/he would not sign out when she/he left.

Administrative nursing staff D stated she/he felt

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F 323	Continued From page 16 the resident could demonstrate safety when out of the facility, knew where she/he was going,and could cross the street safely. The resident was on every 30 minute checks and was unable to obtain the documentation for the checks prior to August 29, 2014. The undated policy and procedure titled Elopement revealed it was the facility's policy to ensure that each resident received adequate supervision and assistive devices to prevent elopement. The facility failed to provide supervision for this resident with moderately impaired cognition and with a history of exit seeking behaviors.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility reported a census of 64 residents. The facility had one main kitchen and one kitchenette located in one of one activity rooms. Based on observation and interview, the facility activity staff failed to properly store and date opened food items, and failed to discard expired food located in 1 activity room refrigerator and cupboard, for one of the five days on site of the survey.	F 371		

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F 371	Continued From page 17 Findings included: - During the initial tour of the facility on 9/2/14 at approximately 10:00 A.M. observation of the refrigerator in the activity room kitchenette revealed (1) unlabeled and undated pie, tomatoes resting on top of raw hamburger meat on the bottom of the refrigerator, undated/labeled (1) pitcher of fluid, (1) jar of minced garlic with no opened date, green substance on mozzarella cheese, one jar of yellow mustard with an expired date of 7/22/14, (1) bottle of ketchup with an expired date of 5/28/14, (1) jar of spicy brown mustard with an expired date of 2/11/14, and (1) jar of Raspberry Vinaigrette dressing with an expired date of 7/5/14. Additionally, during the initial tour on 9/2/14 at approximately 10:00 A.M. observation of the kitchenette in the activity room cupboard revealed (1) jar of opened leaf oregano with an expiration date of 5/2/14, (2) packs, (1) opened and both expired of Jumbo spice world garlic expired on 5/27/14, (1) jar of ground allspice expired on 8/30/13, chicken flavored bouillon cubes expired on 5/2006, natural blend oil opened and expired on 2/14/14, pure honey with no expiration date, and an unlabeled container with spices dated to expire 3/24/2007, all lacked opened dates. Observation also revealed a dirty microwave, oven, and refrigerator in the kitchenette. Interview on 9/2/14 at 10:15 A.M. with activity staff DD stated the activity person was responsible for making sure there were not any outdated items. He/she further revealed all items needed a date when opened and label. He/she stated they expected everything clean, and that activity staff EE handled the cleaning and	F 371		

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F 371	Continued From page 18 checked for outdated items in this kitchenette. Interview on 9/2/14 at 12:15 P.M. with activity staff EE stated he/she was not sure if foods needed an opened date. He/she stated they checked to make sure there were no outdated items every two weeks. He/she further stated the tomatoes on top of the meat should not be there. The policy titled Food Storage with a revised date of 6/8/12 provided by the facility stated staff should label all food items and include the name of the food and date opened, and staff were to discard foods with the expired dates. The facility failed to date opened foods and failed to discard outdated foods, and keep the kitchenette appliances used in food preparation and storage clean.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		

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F 431	Continued From page 19 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: The facility identified a census of 64 residents. Based on observation, record review, and staff interview, the facility failed to properly store medications in one of two medication rooms and failed to date open vaccine stored in one of two treatment rooms. Findings included: - On 9-2-14 at 10:00 A.M. tour of the medication room on D hall revealed nine unlabeled medications in a cup located in the medication cabinet. Direct care staff P stated he/she did not know whose medications or what medications were in the cup. He/she stated the pharmacy came every couple of months to check for outdated medications. On 9-2-14 at 10:05 A.M. tour of treatment room on D hall revealed one opened bottle of tuberculin (sterile aqueous solution of a purified protein fraction for intradermal administration as an aid in the diagnosis of tuberculosis) purified protein	F 431		

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derivative (PPD) diluted aplisol (tuberculin PPD) 5 tuberculin units (tu)/0.1 millimeters (mL) with an expiration date of 3/16 lacked an opened date. Licensed nursing staff I stated he/she did not know if there was supposed to be an opened date on the medications.

Interview on 9-2-14 at 11:00 A.M. with administrative nursing staff D revealed staff should have opened dates on the tuberculin and staff should not have unlabeled medications in the medication room.

The facility policy titled Medication Administration - General Guidelines dated March 2011 stated medications were administered at the time they were prepared and were not pre-poured. The policy further stated once removed from the package or container, staff should dispose of unused doses appropriately.

The facility policy titled Vials and Ampules (Injectable Medications) dated March 2011 stated the initials of the first person to use the vial and the date opened were recorded on multi-dose vials.

The facility failed to properly store and/or dispose of medications not used and to initial and date opened multi-dose vials.